APPENDIX T-1

TECHNICAL GUIDELINES FOR PAPER CLAIM PREPARATION FORM DPA 2209, TRANSPORTATION INVOICE

Please follow these guidelines in the preparation of paper claims for imaging processing to assure the most efficient processing by the Department:

- Claims that are illegible will be returned to the provider.
- Claims with extreme print qualities, either light or dark, will not image.
- Use only one font style on a claim. Do not use bold print, italics, script, or any font that has connecting characters.
- Claims should be typed or computer-printed in capital letters. The character pitch must be 10-12 printed characters per inch, the size of most standard pica or elite typewriters. Handwritten entries should be avoided.
- Do not use punctuation marks, slashes, dashes or any special characters anywhere on the claim form.
- All entries must be within the specified boxes. Do not write in the margins.
- Red ink does not image. Use only black ink for entries on the billing form, attachments and provider signature.
- If corrections need to be made, reprinting the claim is preferred. Correction fluid should be used sparingly.
- Remove the pin-feed strips on claims at the perforations only. Do not cut the strips, as it may alter the document size.
- Attachments containing a black border as a result of photocopying with the copier cover open cannot be imaged. Attachments must have a minimum one-half inch white border at the top and on the sides to ensure proper imaging of the document.
- For attachments containing gray areas, either as part of the original or as a result of photo-copying a colored background, print in the gray area is likely to be unreadable. If information in this area is important, the document should be recopied to eliminate the graying effect as much as possible without making the print too light.
- Attachments should be paper-clipped or rubber-banded to claims. Do not fold invoices or fasten attachments with staples.

Appendix T-1a is a copy of Form DPA 2209, Transportation Invoice. Instructions for completion of the Transportation Invoice follow in the order entries appear on the form. Mailing instructions follow the claim preparation instructions.

The left hand column of the following instructions identifies mandatory and optional items for form completion as follows:

Required	=	Entry always required.
Optional	=	Entry optional - In some cases failure to include an entry will result in certain assumptions by the Department and will preclude correction by the Department of certain claiming errors.
Conditionally Required	=	Entries which are required only under certain circumstances. Conditions of the requirement are identified in the instruction text.
Not Required	=	Fields not applicable to the provision of transportation services.

COMPLETION		**ITEM EXPLANATION AND INSTRUCTIONS**
Required	**1.**	**Provider Name** - Enter the provider name exactly as it appears on the Provider Information Sheet.
Required	**2.**	**Provider Number** - Enter the 12 digit provider key (number) exactly as it appears on the Provider Information Sheet. Do not use spaces or hyphens.
Required	**3.**	**Billing Date** - Enter the date the Transportation Invoice was prepared. Use the six digits, MMDDYY format . (January 15, 2001, is entered as 011501.)
Optional	**4.**	**Provider Reference** - Enter up to ten (10) numbers or letters used in the provider's accounting system for identification. If this field is completed the same data will appear on the provider copy of Form DPA 194-M-1, Remittance Advice.

Optional	**5.**	**Provider Street** - Enter the street address of the provider's primary office. If the address is entered, the Department will, where possible, correct claims suspended due to provider eligibility errors. If address is not entered, the Department will not attempt corrections.
Optional	**6.**	**Provider, City, State, ZIP** - Enter the city, state and ZIP code of your office. (See item 5 above.)
Required	**7.**	**Recipient Name (First, MI, Last)** - Enter the participant's name exactly as it appears on the MediPlan Card or Temporary MediPlan Card or KidCare Card. Separate the name (first, middle initial, last name) by leaving one space between each component. Enter the first name beginning at the left margin of the box.
Required	**8.**	**Recipient Identification Number (RIN)** - Enter the nine digit RIN assigned to the individual on the MediPlan Card or Temporary MediPlan Card or KidCare Card. Do not use the Case Identification Number. If the Temporary MediPlan Card does not contain the RIN, attach a copy of the Card to the invoice on first submittal. The Department will review the claim and determine the correct RIN. The invoice must be submitted in the pre-addressed envelope, DPA 2248, Special Approval Envelope.
Conditionally Required	**9.**	**Birthdate** - An entry is required when the Form DPA 1411, Temporary MediPlan Card does not contain a RIN. Use the six digit, MMDDYY format. (January 28, 2000, is entered as 012800.)
Required	**10.**	**Vehicle License Number** - Enter the vehicle license plate number of the vehicle used for this trip. Please note- This field applies to emergency and non-emergency services. (Include alpha characters if they are part of the license number.)
Required	**11.**	**Service Sections (1 through 8)** - One Service Section is to be completed for each procedure code billed. Do not leave a service section blank between two completed service sections. Providers may complete from one (1) to eight (8) service sections per invoice according to the number of services provided.

Required **Date of Service** - Enter the date on which the transportation service was provided. The MMDDYY format must be used. (January 28, 2001, is entered as 012801.) Multiple dates of service may be billed on the same invoice.

Required **Category of Service (Cat Serv)** - Enter the appropriate code from the list below.

50 - Emergency Ambulance or Helicopter
51 - Non-emergency Ambulance
52 - Medicar
53 - Taxicab
54 - Service Car
55 - Private Automobile
56 - Other

Required **Procedure Code** - For services requiring prior approval, enter the "Approved Procedure Code." For services which do not require prior approval, enter the appropriate code from the provider information sheet.

All providers must bill the appropriate mileage code and charge for each one way-trip. Two procedure codes and two service sections must be completed to bill for round-trip mileage.

Taxicab providers who charge a drop or flag charge are to bill this fee as a base rate and return trip procedure code, as appropriate. The mileage procedure code is to be billed in a separate service section. Taxicab providers who do not charge a drop or flag charge are to bill the mileage procedure code only.

Not Required **Prior Approval Number** - Leave blank.

Required	**Origin Time** - Enter the time the loaded trip began. Time is to be entered as Military Time (If the loaded trip began at 1:30 p.m., the time would be shown as 13:30).
Required	**Destination Time** - Enter the time the loaded trip ended at the destination. Time is to be entered as Military Time.
Conditionally Required	**Total Loaded Miles** - Enter the total loaded miles one way. When a round trip is provided, two mileage procedure codes and service sections must be completed. Miles are to be rounded to the nearest mile (e.g., 11.4 miles is rounded to "11", while 11.5 miles is rounded to "12"). Billing for excess mileage is not allowed.
Required	**Provider Charge** - Enter the provider's usual and customary charge for the procedure code shown in this section. Separate dollars and cents in the proper sections of the field.
Conditionally Required	**Delete** - When an error has been made that cannot be corrected, enter a single capital "X" to delete the entire service section.
Required	**Origin Place** - Enter the appropriate HCPCS modifier selected from the list below. P - Physician's Office D - Medical Service (other than P or H) H - Hospital (Inpatient or Outpatient) R - Residence
Required	**Origin (Facility Name/City or Address/City)** - Enter the facility name or origin place address and the city from which the patient was transported. The origin may be a hospital, clinic, long term care facility, the patient's home address or other location.
Required	**Destination Place** - Enter the appropriate HCPCS modifier from the list shown under Origin Place above.

Required		**Destination (Facility Name/City or Address/City)** - Enter facility name or destination place address and the city to which the patient was transported. The destination may be a hospital, clinic, long term care facility, the patient's home address, etc.
Conditionally Required	**12.**	**TPL Code** - When the patient's Medical or KidCare Eligibility Card lists a TPL (Third Party Liability) Code, the code is to be entered in this field. If two TPL Codes are listed, both codes are to be entered in this field. If the patient has a Third Party Liability coverage but it is not listed on the MediPlan Card or KidCare, enter the appropriate TPL Code from the Third Party Liability Resource Code Directory, Chapter 100, General Appendix 9. If none of the TPL Codes are applicable, enter code "999" and the name of the payment source in Field 13, Uncoded TPL Name. If there is no third party liability resource, no entries are to be made in Fields 12 and 13.

SPENDDOWN - Refer to Chapter 100, Topic 113 for a full explanation of the Spenddown policy. If the patient has a Spenddown obligation, they will either be responsible for the total amount of the charge or will present the provider with a Form DPA 2432 (Split Billing Transmittal). When a Form DPA 2432 is necessary, Form DPA 2209, Transportation Invoice, should be completed as follows:

- Enter 906 in the TPL CODE field.
- Enter a 01 in the TPL STATUS field if there is a patient liability or enter a 04 in the TPL STATUS field if there is no patient liability.
- From the Form DPA 2432, enter the amount from the LESS RECIPIENT LIABILITY AMOUNT field in the TPL AMOUNT field on the Form 2209. This amount may be $0.00.
- From the Form DPA 2432, enter the DATE from the bottom of the form in the TPL DATE field of the Form DPA 2209.
- The TPL fields must be completed in each Service Section that has the same date of service as the SPLIT BILL day. The Spenddown liability is to be divided and reported in the TPL AMOUNT field of each Service Section that has the same date of service.

Conditionally Required

Status - A two digit code indicating the disposition of the third party billing must be entered. No entry is required if no third party liability exists. The TPL Status Codes are:

01 - TPL Adjudicated - total payment shown: TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource. The amount of payment received must be entered in the TPL amount box.

02 - TPL Adjudicated - patient not covered: TPL Status Code 02 is to be entered when the provider is advised by the third party resource that the patient was not insured at the time goods or services were provided.

03 - TPL Adjudicated - service not covered: TPL Status Code 03 is to be entered when advised by the third party resource that goods or services provided are not covered.

04 - TPL Adjudicated - Spenddown met: TPL Status Code 04 is to be entered when the patient's Form DPA 2432, Split Billing Transmittal, shows $0 liability.

05 - Patient not covered: TPL Status Code 05 is to be entered when the patient informs the provider that the third party resources identified on the Medical Eligibility Card is not in force.

06 - Services not covered: TPL Status Code 06 is to be entered when the provider determines that the identified resource is not applicable to the service provided.

07 - Third Party Adjudication Pending: TPL Status Code 07 may be entered when an invoice has been submitted to the third party, thirty (30) days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed.

08 - Not Assigned

09 - Not Assigned

Conditionally Required		**10 - Deductible not met (Medicare excluded):** TPL Status Code 10 is to be entered when the provider has been informed by the third party resource that no payment was made for the service because the patient's deductible was not met.
Conditionally Required	**13.**	**Uncoded TPL Name** - Enter the name of any third party payor coded 999 in the TPL Code field. If two third parties have issued payment for a service, the name of the both parties are to be entered.
Required	**14.**	**Number of Sections** - Enter the number of Service Sections completed correctly on the invoice.
Required	**15.**	**Total Charge** - Enter the sum of all Provider Charges submitted on the invoice.
Conditionally Required	**16.**	**Total Deductions** - Enter the sum of all TPL payments received. If no payments were received, leave blank.
Required	**17.**	**Net Charge** - Enter the difference between the total charge and total deductions.
Required	**18.**	**Signature of Provider/Date** - After reading the certification statement, the provider must sign the completed form. The signature must be handwritten in black or dark blue ink. A stamped or facsimile signature is not acceptable. Unsigned claims will not be accepted by the Department and will be returned to the provider when possible. The signature date is to be entered in MMDDYY format and may be handwritten, typewritten or computer printed.

MAILING INSTRUCTIONS

The Provider Invoice is a single page or two-part form. The provider is to submit the original of the form to the Department as indicated below. The pin-feed guide strip of the two-part continuous feed form should be removed prior to submission to the Department. The copy of the claim should be retained by the provider.

Routine claims are to be mailed to the Department in pre-addressed mailing envelopes, DPA 2244, Transportation Invoice Envelope, provided by the Department.

Mailing address: Healthcare and Family Services
P.O. Box 19105
Springfield, Illinois 62794-9105

Non-routine claims (claims with attachments, such as EOB or split bill transmittals (DPA 2432) are to be mailed to the Department in pre-addressed mailing envelope, Form DPA 2248, NIPS Special Invoice Handling Envelope, which is provided by the Department for this purpose.

Mailing address: Healthcare and Family Services
P.O. Box 19118
Springfield, Illinois 62794-9118

Forms Requisition:

Billing forms may be requested on our Web site at: http://www.hfs.illinois.gov/forms/ or by submitting a DPA 1517 or 1517A as explained in Chapter 100, General Appendix 10.

APPENDIX 1a
Reduced Facsimile of Form DPA 2209, Transportation Invoice

TRANSPORTATION INVOICE
ILLINOIS DEPARTMENT OF PUBLIC AID

IDPA USE ONLY

ELITE PICA

TYPEWRITER ALIGNMENT
<----------**USE CAPITAL LETTERS ONLY**----------> ELITE PICA

1. PROVIDER NAME | 2. Provider Number | 3. Billing Date | 4. Provider Reference

5. Provider Street | 6. Provider City State Zip

7. Recipient Name, (First, MI, Last) | 8. Recipient Number | 9. Birthdate | 10. Vehicle Lic. #

KKK

11. Service Sections

	Date of Service	Cat Serv	Procedure Codee	Prior Approval Number	Orig. Time	Dest. Time	Loaded Miles	Provider Charge	Delete
1									
2									
3									
7									
8									

Orig Place | Origin (Facility Name/City or Address/City) | Dest Place | Destination (Facility Name/City or Address/City)

Note: Center section of form has been removed to enlarge detail. The actual form has 8 Service Sections.

12. TPL Code | Status | TPL Amount | TPL Date | 13. Uncoded TPL Name | 15. Total Charges

12. TPL Code | Status | TPL Amount | TPL Date | 14. # Sects | 16. Total Deductions

17. Net Charge

My signature certifies that: all entries on this claim are true, accurate and complete; the State's Medical Assistance Program pricing limits will be accepted as payment in full; any payments received from this patient or any other third party will be properly credited or paid to the Illinioins Department of Public Aid; records necessary to fully disclose the nature and extent of services provided are maintained and will be made available upon request of State and Federal officials responsible for the various aspects of the State's Medical Assistance Program , as provided under Title XIX of the Social Security Act and applicable State statutes; I provided or directly supervised all services for which a charge appears; I understand payment is made from State and Federal funds and that any falsification or concealment of material fact may lead to appropriate legal action; in compliance with the Civil Rights Act of 1964, services were provided without discrimination on the grounds of race, color or national origin; and handicapped persons are afforded the rights and consideration specified in Section 504 of the Rehabilitation Act of 1973 and Part 84 of the Code of Federal Regulations.

Signature Date

DPA 2209 (R-6-90) Completion mandatory, Ill. Rev. Stat., Ch. 23, P.A. Code, penalty non-payment. Form Approved by the Forms Management Center. IL478-1210

APPENDIX T-2

BILL PREPARATION AND MAILING INSTRUCTIONS FOR MEDICARE CROSSOVER CLAIMS (MEDICARE ELIGIBLE PATIENTS - AMBULANCE AND AIR TRANSPORT ONLY)

Definition of a Medicare Crossover Claim - A medical claim first adjudicated by Medicare where the charge is approved and the Department assumes responsibility for full or partial payment of coinsurance and/or deductible amounts for a Medical Assistance eligible participant.

Billing Methods - The majority of crossover claims that are processed by the Department are transmitted electronically from the Medicare Part B Carrier (MPBC). See Item I below. In certain situations, it may be necessary to submit charges on a paper claim, even though the MPBC sent an electronic claim. See Item II on the next page.

ITEM I - ELECTRONIC DATA INTERCHANGE (EDI)

Services billed to the MPBC as first payor are crossed over to the Department for consideration of payment of the patient's coinsurance or deductible.
For each service transmitted, the MPBC prints a special message on the Medicare Remittance Notice which reads, "**Claim Information Forwarded to: Illinois Depart Public Aid".**

When the following conditions are met, the MPBC will electronically transmit a claim to the Department:

- The patient is covered by both Medicare Part B and the Department on the date of service.
- The Department has advised the MPBC that the patient is an eligible Healthcare and Family Services participant by sending the patient's recipient identification number on a monthly recipient eligibility tape.
- The charge is approved by the MPBC. The Medicare Allowable becomes the same as the provider charge shown on the Department's Remittance Advice.
- The provider has accepted assignment of Medicare benefits.
- The provider's Medicare enrollment number is correctly shown on the Department's provider file. (Check your Provider Information Sheet.)

ITEM II - PAPER MEDICARE CROSSOVER CLAIMS (HCFA 1491)

Form HCFA 1491, Request for Medicare Payment - This is the only valid paper claim form that will be accepted for processing by the Department for transportation services as crossover claims. The HCFA 1491 must contain the same information which was submitted to Medicare Part B. **Do not use form DPA 2209**. Listed below are the situations that would require a paper claim be submitted to the Department;

- the claim did not cross over electronically,
- a service was rejected during processing by the Department and is being resubmitted,
- an attachment is required, such as verification of an additional insurance benefit, spenddown attachment, etc.

Submittal of Form HCFA 1491 - Request for Medicare Payment

The fields on HCFA 1491 should be completed in accordance with instructions in the Medicare Part B provider handbook with additional entries for IDPA as follows:

ITEM 5	Name and Address of Organization or Agency - Enter "IDPA" and the patient's 9-digit Recipient Identification Number as shown on the MediPlan card.
ITEM 23	Name and address of the provider - Enter the provider name and address as shown on the IDPA Provider Information Sheet. Also, enter the12-digit IDPA provider enrollment number directly under the provider address.
ITEM 24	Assignment of patient's bill - The "accept" box must be checked. The provider must have accepted assignment of Medicare benefits in order for IDPA to assume any patient liability.

Attach the Medicare Remittance Notice which matches the HCFA 1491 according to the following instructions:

- Submit a legible copy of the **ENTIRE** MPBC Remittance Notice for processing.
- Do not highlight or circle any information on the MPBC Remittance Notice.

BILLING MEDICARE DENIED SERVICES

A message that the claim crossed over may appear on the Medicare Remittance Notice for denied services. This occurs when some services are paid and some denied during Medicare Part B processing.

Denied services are not processed as crossovers. If the Medicare denial reason is the patient was not entitled to Part B on the service date or the service was non-covered by Medicare, the claim may be re-submitted with the Medicare Remittance Notice. For other denial reasons, a request for reconsideration should be filed with Medicare.

If charges are approved after the Medicare review, the service will then be crossed over electronically to the Department and processed as a crossover claim. However, if Medicare upholds the original denial decision submit a completed DPA 2209 with a copy of both the Medicare original and review Remittance Notice.

Refer to billing instructions in Appendix T-1 for completion of Form DPA 2209, Transportation Invoice, to bill the Department for services denied by Medicare.

APPENDIX T-3

EXPLANATION OF INFORMATION ON PROVIDER INFORMATION SHEET

The Provider Information Sheet is produced when a provider is enrolled in the Department's Medical Programs. It will also be generated when there is a change or update to the provider record. The Department will mail the sheet to the provider. The sheet serves as the provider's record of all the data that appears on the Provider Data Base.

The following information will appear on the Provider Information Sheet. A sample of a Provider Information Sheet is attached as Appendix T-3a. The item numbers that correspond to the explanations below appear in small circles ◯ on the sample form.

FIELD	EXPLANATION
(1) **PROVIDER KEY**	This number uniquely identifies the provider and must be used as the provider number when billing charges to the Department.
(2) **PROVIDER NAME AND LOCATION**	This area contains the **NAME AND ADDRESS** of the provider as carried in the Department's records. The three-digit **COUNTY** code identifies the county in which the provider's primary office is located. It is also used to identify a state if the provider's primary office location is outside of Illinois. The **TELEPHONE NUMBER** is the primary telephone number of the provider's primary office.
(3) **ENROLLMENT SPECIFICS**	This area contains basic information reflecting the manner in which the provider is enrolled with the Department. **PROVIDER TYPE** is a three-digit code, the corresponding narrative indicates the provider's classification. 070 = Ambulance 071 = Medicar 072 = Taxicab and Service Car 073 = Other Transportation 074 = Hospital-based Transportation

ORGANIZATION TYPE is a two-digit code with corresponding narrative indicating the legal structure of the environment in which the provider primarily performs services. The possible codes are:

01 = Individual Practice
02 = Partnership
03 = Corporation

ENROLLMENT STATUS is a one-digit code with corresponding narrative which indicates whether or not the provider is currently an active participant in the Department's Medical Programs. The possible codes are:

B = Active
I = Inactive
N = Non Participating

Disregard the term NOCST if it appears in this item.

Immediately following the enrollment status indicator are the **BEGIN** date indicating when the provider was most recently enrolled in Department's Medical Programs and the **END** date indicating the end of the provider's most current enrollment period. If the provider is still actively enrolled, the word "ACTIVE" will appear in the **END** date field.

EXCEPTION INDICATOR may contain a one-digit code and corresponding narrative indicating that the provider's claims will be reviewed manually prior to payment. The possible codes are:

A = Intent to Terminate
B = Expired License
C = Citation to Discover Assets
D = Delinquent Child Support
F = Fraud Investigations
G = Garnishment
I = Indictment
L = Student Loan Suspensions
R = Intent to Terminate/Recovery
S = Exception Requested By Provider Participation Unit
T = Tax Levy
X = Tax Suspensions

If this item is blank, the provider has no exception.

Immediately following the **EXCEPTION INDICATOR** are the **BEGIN** date indicating the first date when the provider's claims were to be manually reviewed and the **END** date indicating the last date the provider's claims were to be manually reviewed. If the provider has no exception, the date fields will be blank.

AGR (Agreement) indicates whether the provider has a form DPA 1413T, Provider Agreement, on file and the provider is eligible to submit claims electronically. Possible entries are YES or NO.

4 **CERTIFICATION/ LICENSE NUMBER**

This is a unique number identifying the license issued by a state agency authorizing a provider to practice or conduct business. This entry is followed by the **ENDING** date indicating when the license will expire.

5 **S.S.#**

This is the provider's Social Security or FEIN number.

6 **PROCEDURE CODE/RATE AND CATEGORIES OF SERVICE**

This area identifies the types of services, procedure(s) and current rate a provider is enrolled to provide.

PROCEDURE CODE - Identifies and defines the specific procedure(s) codes the provider is enrolled to perform. Immediately following the procedure description is the **DATE** the provider has been approved to render services and the reimbursable **RATE** approved by the Department for each listed service rendered by the provider.

ELIGIBILITY CATEGORY OF SERVICE contains one or more three-digit codes and corresponding narrative indicating the types of service a provider is authorized to render to patients covered under the Department's Medical Programs. The possible codes are:
050 - Emergency Ambulance or Helicopter
051 - Non-Emergency Ambulance
052 - Medicar
053 - Taxicab
054 - Service Car
055 - Private Automobile
056 - Other
Each entry is followed by the date that the provider was approved to render services for each category listed.

7 **PAYEE INFORMATION**

This area records the name and address of any persons or entities authorized to receive payments on behalf of the provider.

If no payee number is designated on a claim form, the Department will reject the claim.

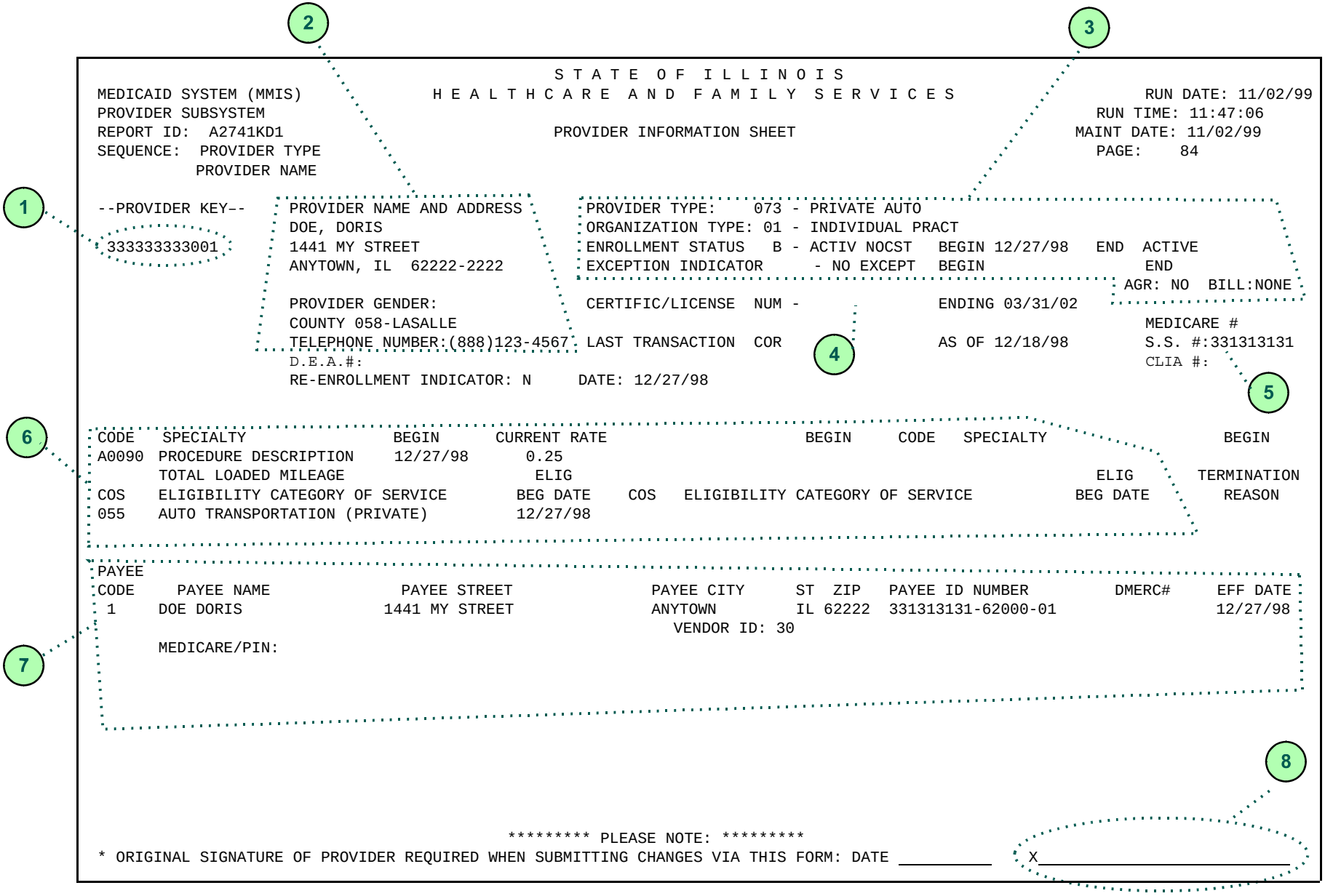
PAYEE ID NUMBER is a sixteen-digit identification number assigned to each payee to whom warrants may be issued. A portion of this number is used for tax reporting purposes, therefore no payments can be made to a payee unless the number is on file. Immediately following this number is the effective date when payment may be made to each payee on behalf of the provider.

The **MEDICARE/PIN** or the **DMERC** # is the number assigned to the payee by the Medicare Carrier to cross-over Medicare billable services.

8 **SIGNATURE**

The provider is required to affix an original signature when submitting changes to Healthcare and Family Services.

APPENDIX T-3a
Reduced Facsimile of Provider Information Sheet



APPENDIX T-4

SAMPLE UNIFORM TRIP TICKET FOR PROVIDERS OF SERVICE CAR, MEDICAR AND TAXICAB SERVICES

The sample Uniform Trip Ticket may be used by providers of service car, medicar and taxicab services as a way to document information pertinent to each trip. **The Department does not issue this form, or require that providers use it for documentation.** However, it does contain information that can assist providers in fulfilling their record requirements.

Sample
Medicar / Service Car / Taxicab Uniform Trip Ticket

Recipient Information

Name_____ **Recipient Identification Number**_____

Address_____

Requestor Information

Name_____ **Address**_____

Vehicle Information

License Plate Number_____ **Type of Vehicle**: _____**Medicar** _____**Service Car** _____**Taxicab**

Medical Provider Information

Name of Medical Provider_____ **Type of Facility**_____

Trip Information

Date of Trip _____ **Prior Approval Number** _____

	Initial Trip	**Return Trip**
Name of Driver		
Drop off Address		
No. of Miles Traveled		
Name of Employee Attendant		
Pick-Up/Drop-Off Time	_____/_____	_____/_____

Was the recipient accompanied on the trip?	**____Yes**	**____No**	**____Yes**	**____ No**
Was the recipient able to walk unassisted?	**____Yes**	**____No**	**___Yes**	**____ No**
Was a stretcher used?	**____Yes**	**____No**	**___Yes**	**____ No**

Explain the medical necessity of the trip/s if no prior approval was required. Also, explain the need for an attendant or stretcher, if used:

_____

Signature of person completing form_____

Printed Name_____ **Date**_____